STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005013	A. BUILDING: _____ B. WING _____	03/30/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SULLIVAN COUNTY COMMUNITY HOSPITAL	2200 N SECTION ST SULLIVAN, IN 47882

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS HFAP Surveyor: 33212 Facility Number: 005013 Type of Survey: State Licensure Off Site HFAP Accreditation Survey Date of HFAP On Site Survey - Hospital full survey 3/28-30/2012 Date of ISDH off site review - - 9/9/2013 Reviewer/Surveyor Nancy Otten RN, PHNS Based on review of the 3/28-30/2012, HFAP Accreditation Survey Report, it has been determined that Sullivan County Community Hospital meets the requirements for Hospital Licensure in Indiana for 2012.	S 000		